blue of california

CalPERS

Health Maintenance Organization (HMO)

Your Medicare Health Benefits and Services/Prescription Drug Coverage as a Member of Blue Shield 65 Plus (HMO)

Evidence of Coverage

Effective January 1, 2010 – December 31, 2010

Blue Shield 65 Plus (HMO) is a Group Medicare Advantage-Prescription Drug (GMA-PD) plan for Medicare-eligible retired beneficiaries, residing in specified service areas, who are not eligible for enrollment in Blue Shield of California's NetValue or Access+ Basic health benefit plans offered under the Public Employees' Medical and Hospital Care Act.

Contracted by the CalPERS Board of Administration
Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

January 1 – December 31, 2010

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Blue Shield 65 Plus (HMO)

This booklet gives you the details about your Medicare health and prescription drug coverage from January 1 – December 31, 2010. It explains how to get the health care and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Blue Shield 65 Plus (HMO) Member Services:
For help or information, please call Member Services or go to our plan website at blueshieldca.com/calpers.
1-800-776-4466 (Calls to these numbers are free.)
TTY users call: 1-800-794-1099

From November 15, 2009 through March 1, 2010, you can reach us seven days a week from 7:00 a.m. to 8:00 p.m. Pacific Standard Time. However, after March 2, 2010, your call will be handled by our automated phone system, Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.

This plan is offered by Blue Shield of California, referred throughout the Evidence of Coverage as "we," "us," or "our." Blue Shield 65 Plus (HMO) is referred to as "plan" or "our plan."

Blue Shield 65 Plus (HMO) is a Medicare-approved HMO with a Medicare Advantage-Prescription Drug Plan contract. Blue Shield of California has a contract with the federal government that is renewed annually and the availability of coverage beyond the end of the current contract year is not guaranteed.

This information may be available in a different format, including large print. Please call Member Services at the number listed above if you need plan information in another format or language.

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Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member of Blue Shield 65 Plus (HMO)

SECTION 1 Introduction

Section 1.1 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

- You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Blue Shield 65 Plus (HMO).
- There are different types of Medicare Advantage Plans. Blue Shield 65 Plus (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization).

This plan is offered by Blue Shield of California, referred throughout the Evidence of Coverage as "we," "us," or "our." Blue Shield 65 Plus (HMO) is referred to as "plan" or "our plan."

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a member of Blue Shield 65 Plus (HMO).

Section 1.2 What does this Chapter tell you?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- What is your plan's service area?
- How do you keep the information in your membership record up to date?

Section 1.3 What if you are new to Blue Shield 65 Plus (HMO)?

If you are a new member, then it's important for you to learn how the plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Member Services (contact information is on the cover of this booklet).

Section 1.4 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Blue Shield 65 Plus (HMO) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Blue Shield 65 Plus (HMO) between January 1, 2010 and December 31, 2010.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve Blue Shield 65 Plus (HMO) each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your five eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- you are entitled to Medicare Part A
- -- *and* -- you are enrolled in Medicare Part B
- -- *and* -- you do not have End Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated
- -- *and* -- you meet CalPERS eligibility requirements

Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by providers such as hospitals, skilled nursing facilities or home health agencies.

- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

Section 2.3 Here is the plan service area for Blue Shield 65 Plus (HMO)

Although Medicare is a Federal program, Blue Shield 65 Plus (HMO) is available only to individuals who **live** in our plan service area. A Post Office box or rental mailbox cannot be used to determine whether you meet the residence eligibility requirements for this plan. Your permanent residence must be used to determine eligibility. To stay a member of our plan, you must keep living in this service area. The service area is described below.

In instances when a ZIP code spans more than one county, your permanent residence must be in the portion of the ZIP code that is in the county that is in our plan service area. That means, even if your ZIP code is listed below, your home would not be inside our service area if you live in a county that is not part of our service area and you would not be eligible for this plan.

Subject to approval by the Centers for Medicare & Medicaid Services (CMS), we may reduce our Service Area effective any **time after** January 1 by giving prior written notice to your Group. We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service. If you have a question about whether a ZIP code is currently included in the Service Area, please contact CalPERS at **888 CalPERS (or 888-225-7377) [TTY/TDD: (916) 795-3240]** between 8 a.m. and 5 p.m., Monday through Friday, excluding holidays.

Our service area includes these counties in California: **Los Angeles County, Orange County, San Luis Obispo County and Ventura County**

Our service area includes these parts of counties in California:

Fresno County, the following ZIP codes only:

93602	93652	93709	93727	93765	93793
93606	93657	93710	93728	93771	93794
93607	93660	93711	93729	93772	93844
93609	93662	93712	93730	93773	93888
93611	93664	93714	93740	93774	
93612	93667	93715	93741	93775	
93613	93668	93716	93744	93776	
93616	93675	93717	93745	93777	
93619	93701	93718	93747	93778	
93625	93702	93720	93750	93779	
93626	93703	93721	93755	93780	
93627	93704	93722	93759	93784	
93630	93705	93723	93760	93786	
93648	93706	93724	93761	93790	
93650	93707	93725	93762	93791	
93651	93708	93726	93764	93792	

Kern County, the following ZIP codes only:

93203	93263	93302	93309	93384	93518
93206	93268	93303	93311	93385	93531
93216	93276	93304	93312	93386	
93220	93280	93305	93313	93387	
93226	93285	93306	93314	93388	
93241	93287	93307	93380	93389	
93250	93301	93308	93383	93390	

Madera County, the following ZIP codes only:

93614	93637	93639
93636	93638	93645

Riverside County, the following ZIP codes only:

91752	92501	92521	92555	92584	92878
92220	92502	92522	92556	92585	92879
92223	92503	92530	92557	92586	92881
92230	92505	92531	92561	92587	92882
92234	92506	92543	92562	92589	92883
92235	92507	92544	92563	92590	
92335	92508	92545	92564	92591	
92258	92513	92546	92567	92592	
92262	92514	92548	92570	92593	
92263	92515	92549	92571	92595	
92264	92516	92551	92572	92596	
92282	92517	92552	92581	92599	
92292	92518	92553	92582	92860	
92320	92519	92554	92583	92877	

San Bernardino County, the following ZIP codes only:

91701	92284	92325	92350	92385	92411
91708	92285	92326	92352	92386	92412
91710	92286	92327	92354	92391	92413
91729	92301	92329	92356	92392	92414
91730	92305	92331	92357	92393	92415
91737	92307	92333	92358	92394	92418
91739	92308	92334	92359	92395	92420
91743	92311	92335	92368	92397	92423
91758	92312	92336	92369	92399	92424
91761	92313	92337	92371	92401	92427
91762	92314	92339	92372	92402	92880

91763	92315	92340	92373	92403	
91764	92316	92341	92374	92404	
91784	92317	92342	92375	92405	
91785	92318	92344	92376	92406	
91786	92321	92345	92377	92407	
91798	92322	92346	92378	92408	
92256	92324	92347	92382	92410	

If you plan to move out of the service area, please contact Member Services.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and drugs

While you are a member of our plan, you must use our membership card whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:

FRONT

BACK

As long as you are a member of our plan **you must <u>not</u> use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 The *Provider Directory*: your guide to all providers in the plan's network

Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory.* This directory lists our network providers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment in full. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, out of the area), out-of-area dialysis services, and cases in which Blue Shield 65 Plus (HMO) authorizes use of non-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider Directory* on the *Find a Provider* section of **blueshieldca.com**. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

Section 3.3 The *Pharmacy Directory*: your guide to pharmacies in our network

What are "network pharmacies"?

Our *Pharmacy Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

We will send you a complete *Pharmacy Directory* **at least once every three years**. Every year that you don't get a new *Pharmacy Directory*, we'll send you an update that shows changes to the directory.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are on the front cover). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website in the *Pharmacy* section of **blueshieldca.com**.

Section 3.4 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by Blue Shield 65 Plus (HMO). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Blue Shield 65 Plus (HMO) Drug List.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (the *Pharmacy* section of **blueshieldca.com**.) or call Member Services (phone numbers are on the front cover of this booklet).

Section 3.5 Reports with a summary of payments made for your prescription drugs

When you use your prescription drug benefits, we will send you a report to help you understand and keep track of payments for your prescription drugs. This summary report is called the *Explanation of Benefits*.

The *Explanation of Benefits* tells you the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services.

SECTION 4 Your monthly premium for Blue Shield 65 Plus (HMO)

Section 4.1 How much is your plan premium?

Your former employer group is responsible for paying any monthly plan premiums to the plan. If you are responsible for any contribution to the monthly plan premiums, CalPERS will tell you the amount and how to pay your former employer group. You can contact CalPERS at **888 CalPERS** (or 888-225-7377) [TTY/TDD: 1-800-735-2929] 8 a.m. to 5 p.m., Monday through Friday.

Cost of the Program

Type of Enrollment Monthly Rate

Employee only	$299.53
Employee and one dependent	$599.06
Employee and two or more dependents...	$898.59

State Employees and Annuitants

The rates shown above are effective January 1, 2010, and will be reduced by the amount the State of California contributes toward the cost of your health benefit plan. These contribution amounts are subject to change as a result of collective bargaining agreements or legislative action. Any such change will be accomplished by the State Controller or affected retirement system without any action on your part. For current contribution information, contact your retirement system health benefits officer.

Contracting Agency Employees and Annuitants

The rates shown above are effective January 1, 2010, and will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. This amount varies among public agencies. For assistance on calculating your net contribution, contact your agency or retirement system health benefits officer.

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about these programs. If you qualify for one of these programs, enrolling in the program might make your monthly plan premium lower.

If you are *already enrolled* and getting help from one of these programs, **some of the payment information in this *Evidence of Coverage* may not apply to you**. We will be sending you a separate mailing, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (Low Income Subsidy Rider), that tells you about your drug coverage. If you don't receive this mailing, please call Member Services and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Member Services are on the front cover.

In some situations, your plan premium could be more

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't keep their coverage. For these members, the plan's monthly premium will be higher. It will be the applicable amount listed above plus the amount of their late enrollment penalty.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 9 explains the late enrollment penalty.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B. You must continue paying your Medicare Part B premium for you to remain as a member of the plan.

- Your copy of *Medicare & You 2010* tells about these premiums in the section called "2010 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2010* from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in October and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for Extra Help or if you lose your eligibility for Extra Help during the year. If a member qualifies for Extra Help with their prescription drug costs, Extra Help will pay part of the member's monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about Extra Help in Chapter 2, Section 7.

What if you believe you have qualified for "Extra Help"

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

Please call Member Services at the number listed in Section 8. If it is determined that evidence is needed, you can mail or fax in your evidence.

MAIL: Blue Shield 65 Plus (HMO), PO Box 927, Woodland Hills, CA 91365
FAX: 1-800-303-5828

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Personal Physician and Medical Group.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered for you**. Because of this, it is very important that you help us keep your information up to date.

Call Member Services to let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are on the cover of this booklet).

Chapter 2. Important phone numbers and resources

SECTION 1 Blue Shield 65 Plus (HMO) contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to Blue Shield 65 Plus (HMO) Member Services. We will be happy to help you.

Member Services	
CALL	**1-800-776-4466.** Calls to this number are free. From November 15, 2009 through March 1, 2010, you can reach us seven days a week from 7:00 a.m. to 8:00 p.m. Pacific Standard Time. However, after March 2, 2010, your call will be handled by our automated phone system on Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
TTY	**1-800-794-1099.** Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. From November 15, 2009 through March 1, 2010, you can reach us seven days a week from 7:00 a.m. to 8:00 p.m. Pacific Standard Time. However, after March 2, 2010, your call will be handled by our automated phone system on Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
FAX	1-800-303-5828
WRITE	Blue Shield 65 Plus (HMO), P.O. Box 927, Woodland Hills, CA 91365-9856
WEBSITE	www.blueshieldca.com

How to contact us when you are asking for a coverage decision about your medical care or Part D Prescription Drugs

You may call us if you have questions about our coverage decision process.

Coverage Decisions for Medical Care	
CALL	**1-800-776-4466.** Calls to this number are free.
Coverage Decisions for Part D Prescription Drugs	
CALL	**1-800-535-9481.** Calls to this number are free.
TTY	**1-800-794-1099.** Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-800-303-5828
WRITE	Blue Shield 65 Plus (HMO), P.O. Box 927, Woodland Hills, CA 91365-9856

For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

How to contact us when you are making an appeal about your medical care or Part D Prescription Drugs

Appeals for Medical Care or Part D Prescription Drugs	
CALL	**1-800-776-4466.** Calls to this number are free.

TTY	**1-800-794-1099.** Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-800-303-5828
WRITE	Blue Shield 65 Plus (HMO), P.O. Box 927, Woodland Hills, CA 91365-9856

For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

How to contact us when you are making a complaint about your medical care or Part D prescription drugs

Complaints about Medical Care or Part D prescription drugs	
CALL	**1-800-776-4466.** Calls to this number are free.
TTY	**1-800-794-1099.** Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-800-303-5828
WRITE	Blue Shield 65 Plus (HMO), P.O. Box 927, Woodland Hills, CA 91365-9856

For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for more information.

Payment Requests	
CALL	**1-800-776-4466.** Calls to this number are free.
TTY	**1-800-794-1099.** Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-800-303-5828
WRITE	Blue Shield 65 Plus (HMO), P.O. Box 927, Woodland Hills, CA 91365-9856

CalPERS Office of Employer and Member Health Services	
CALL	**888 CalPERS (or 888-225-7377)** **8 a.m. to 5 p.m., Monday through Friday.** Calls to this number are free.
TTY	**1-800-735-2929** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-916-795-1277
WRITE	CalPERS Office of Employer and Member Health Services PO Box 942714 Sacramento, CA 94229-2714

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage Organizations including us.

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the State Health Insurance Assistance Program is called Health Insurance Counseling and Advocacy Program (HICAP).

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

HICAP	
CALL	1-800-434-0222 (In-State calls only) 1-916-231-5110 (Out-of-State calls)
WRITE	HICAP 5380 Elvas Avenue, Suite 104 Sacramento, CA 95819
WEBSITE	www.medicare.gov under “Search Tools” by selecting “Helpful Phone Numbers and Websites.”

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization in each state. In California, the Quality Improvement Organization is called Health Services Advisory Group, Inc. (HSAG).

HSAG has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. HSAG is an independent organization. It is not connected with our plan.

You should contact HSAG in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

HSAG	
CALL	1-800-841-1602. Calls to this number are free.
TTY	1-800-881-5980 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Health Services Advisory Group, Inc. Attn: Beneficiary Protection 5201 W. Kennedy Boulevard, Suite 900, Tampa, FL 33609-1822
WEBSITE	www.hsag.com/camedicare

SECTION 5 Social Security

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or end stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare and pay the Part B premium. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security Administration	
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. In California, this program is called Medi-Cal. Some people with Medicare are also eligible for Medi-Cal. Medi-Cal has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medi-Cal and its programs, contact your local Medi-Cal office or please call the California Department of Social Services.

California Department of Social Services	
CALL	1-800-952-5253. Calls to this number are free.
TTY	1-800-952-8349. Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	PO Box 944243, Sacramento, CA 94244

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This Extra Help also counts toward your out-of-pocket costs for covered drugs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

If you think you may qualify for Extra Help, call Social Security (see Section 5 of this chapter for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office (see Section 6 of this chapter for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

In California, the Genetically Handicapped Persons Program (GHPP) is a state organization that provides limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs.

GHPP	
CALL	1-800-639-0597. Calls to this number are free. 1-916-327-0470
WRITE	Genetically Handicapped Persons Program MS8105 PO Box 997413 Sacramento CA 95899-7413
WEBSITE	www.dhs.ca.gov/PCFH/cms/ghpp

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
CALL	1-877-772-5772. Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	http://www.rrb.gov

SECTION 9 Do you have "group insurance" or other health insurance from another employer?

If you (or your spouse) get benefits from your (or your spouse's) other employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter tells things you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay as your share of the cost when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical benefits chart, what is covered and what you pay*).

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care that is covered by the plan

Blue Shield 65 Plus (HMO) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. It needs to be accepted treatment for your medical condition.
- **You have a Personal Physician who is providing and overseeing your care.** As a member of our plan, you must choose a Personal Physician (for more information about this, see Section 2.1 in this chapter).

- In most situations, your Personal Physician must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.2 of this chapter.
- Referrals from your Personal Physician are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your Personal Physician (for more information about this, see Section 2.3 of this chapter).

- **You generally must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from a non-network provider (a provider who is not part of our plan's network) will not be covered. *Here are two exceptions:*
  - The plan covers emergency care or urgently needed care that you get from a non-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from a non-network provider. In this situation, you must obtain prior authorization for the care to be covered and you will pay the same as you would pay if you got the care from a network provider. If you find yourself in this situation, please call Member Services at the number on your Blue Shield 65 Plus (HMO) identification card.

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You must choose a Personal Physician to provide and arrange for your medical care

What is a Personal Physician and what does the Personal Physician do for you?

When you become a Member of Blue Shield 65 Plus (HMO), you must choose a Network Provider to be your Personal Physician. Your Personal Physician is a health care professional who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your Personal Physician. Your Personal Physician will also coordinate the rest of the Covered Services you get as a plan Member. For example, in order for you to see a Specialist, you usually need to get your Personal Physician's approval first (this is called getting a "Referral" to a Specialist).

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your Personal Physician (such as giving you a Referral to see a

Specialist). In some cases, your Personal Physician will need to get Prior Authorization (prior approval) from us or your Physician Group. Since your Personal Physician will provide and coordinate your medical care, you should have all of your past medical records sent to your Personal Physician's office.

How do you choose a Personal Physician?

When you join Blue Shield 65 Plus (HMO), you receive a Provider Directory that shows the physicians who provide care for our Members, along with the Physician Group and affiliated Specialists. The Provider Directory also includes the Network Hospital or Hospitals at which you may receive care.

You choose your Personal Physician from this list of providers and write the physician's name and ID number on your enrollment form. It's possible that your current physician is already part of the Blue Shield 65 Plus (HMO) Provider Network.

When you choose your Personal Physician, you are also choosing the Hospitals and specialty Network associated with your Personal Physician. If there is a particular network Specialist or Hospital you want to use, check first to be sure your Personal Physician makes Referrals to that Specialist or uses that Hospital.

Once you are enrolled in the Plan, we send you a membership card. The name and office telephone number of your Personal Physician is printed on your membership card.

Changing your Personal Physician

You may change your Personal Physician for any reason, at any time. Also, it's possible that your Personal Physician might leave our plan's network of providers and you would have to find a new Personal Physician.

To change your Personal Physician, call Member Services. If you call by the 15th of the month, your transfer to a new Personal Physician will be effective on the first day of the following month.

When you call, be sure to tell Member Services if you are seeing Specialists or getting other Covered services that needed your Personal Physician's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your Personal Physician. They will also check to be sure the Personal Physician you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new Personal Physician, and tell you when the change to your new Personal Physician will take effect.

They will also send you a new membership card that shows the name and phone number of your new Personal Physician.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your Personal Physician?

You can get the services listed below without getting approval in advance from your Personal Physician.

- Routine women's health care, which include breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from non-network providers.
- Urgently needed care from non-network providers when network providers are temporarily unavailable or, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.
- Routine hearing services, when you get these services from Network Providers.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer.
- Cardiologists, who care for patients with heart conditions.
- Orthopedists, who care for patients with certain bone, joint, or muscle conditions.

When your Personal Physician thinks that you need specialized treatment, they will request a referral (approval in advance) to see a plan Specialist or certain other providers. For some types of referrals, your Personal Physician may need to get approval in advance from our Plan (this is called getting "prior authorization").

It is very important to get a referral (approval in advance) from your Personal Physician before you see a plan Specialist or certain other providers (there are a few exceptions, including routine women's health care that we explain later in this section). **If you don't have a referral (approval in advance) before you get services from a Specialist, you may have to pay for these services yourself.**

If the Specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your Personal Physician for the first visit covers more visits to the Specialist.

When you choose your Personal Physician, you are also choosing the Hospital and specialty Network associated with your Personal Physician.

If there are specific Specialists you want to use, find out whether your Personal Physician sends patients to these Specialists. Each Network Personal Physician has certain plan Specialists they use for referrals. This means that the Personal Physician you select may determine the specialists you may see. You may generally change your Personal Physician at any time if you want to see a plan Specialist that your current Personal Physician can't refer you to. Earlier in this section, under "Changing your Personal Physician?" we tell you how to change your Personal Physician. If there are specific hospitals you want to use, you must first find out whether your Personal Physician uses these hospitals.

What if a specialist or another network provider leaves our plan?

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan network. If this happens, you will have to switch to another provider who is part of our plan network. Member Services can assist you in finding and selecting another provider.

SECTION 3 How to get covered services when you have an emergency or an urgent need for care

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your Personal Physician.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is on the back of your Blue Shield 65 Plus (HMO) membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the medical benefits chart

in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by non-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will generally cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- *– or –* the additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for care

What is "urgently needed care"?

"Urgently needed care" is a non-emergency situation when:

- You need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.
- Because of the situation, it isn't reasonable for you to obtain medical care from a network provider.

What if you are in the plan's service area when you have an urgent need for care?

Whenever possible, you must use our network providers when you are in the plan's service area and you have an urgent need for care. (For more information about the plan's service area, see Chapter 1, Section 2.3 of this booklet.)

In most situations, if you are in the plan's service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter. If the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, our plan will cover urgently needed care that you get from a non-network provider.

What if you are outside the plan's service area when you have an urgent need for care?

Suppose that you are temporarily outside our plan's service area, but still in the United States. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan's network. In this situation (when you are outside the service area and cannot get care from a network provider), our plan will cover urgently needed care that you get from any provider.

See "Emergency care" and "Urgently needed care" in the benefit chart in Chapter 4 for more information on coverage when you are outside of the United States.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask the plan to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want our plan to pay our share of the costs by reimbursing you for payments you have already made.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us so that we can pay our share of the costs for your covered medical services.

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Blue Shield 65 Plus (HMO) covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services at the number on the front cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once a benefit limit has been reached, whatever you pay for services will not count toward your out-of-pocket maximum. See Chapter 4 for more information on benefit limits and maximums. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, *you will be responsible for paying all costs for your participation in the study*.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from our plan or your Personal Physician. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.
3. We can keep track of the health care services that you receive as part of the study.

If you plan on participating in a clinical research study, contact Member Services (see Chapter 2, Section 1 of this *Evidence of Coverage*).

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, **Medicare will pay for the covered services you receive as part of the research study.** Medicare pays for routine costs of items and services. Examples of these items and services include the following:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

When you are part of a clinical research study, **Medicare will *not* pay for any of the following**:

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive as a participant in the clinical research study. Because you are a member of our plan, you *do not* have to pay the deductibles for Original Medicare Part A or Part B.

Do you want to know more?

To find out what your coinsurance would be if you joined a Medicare-approved clinical research study, please call us at Member Services (phone numbers are on the cover of this booklet).

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (http://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, our plan will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

- – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply (see Chapter 4 for more information on Medicare Inpatient Hospital coverage limits).

Chapter 4. Medical benefits chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of Blue Shield 65 Plus (HMO). Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services.

Section 1.1 What types of out-of-pocket costs do you pay for your covered services?

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service.
- **"Coinsurance"** means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service.

Some people qualify for programs to help them pay their out-of-pocket costs for Medicare. If you are enrolled in these programs, you may still have to pay the Medicaid copayment, depending on the rules in your state.

SECTION 2 Use this *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The medical benefits chart on the following pages lists the services Blue Shield 65 Plus (HMO) covers and what you pay for each service. The services listed in the Medical Benefits Chart are covered only when all coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Except in the case of preventive services and screening tests, your services (including medical care, services, supplies, and equipment) *must* be medically necessary. Medically

necessary means that the services are an accepted treatment for your medical condition.

- You receive your care from a network provider. In most cases, care you receive from a non-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from a non-network provider.
- You have a Personal Physician who is providing and overseeing your care. In most situations, your Personal Physician must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in bold at the beginning of each section.

Services that are covered for you	**What you must pay** when you get these services
Inpatient Care	
Important: **Inpatient Care Services require Prior Authorization (approval in advance)** from your Physician Group or Blue Shield 65 Plus (HMO) to be covered, except for emergency and urgent out-of-area services.	
Inpatient hospital care Covered services include: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive/coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint used. • Physician Services	For each Medicare-covered stay in a Network Hospital you pay: $0 per admission. There is no limit to the number of days per Hospital stay. If you get authorized inpatient care at a non-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Acute inpatient chemical dependency detoxification	For each Medicare-covered stay in a Network Hospital you pay: $0 per admission.
Substance abuse and rehabilitation services	For each Medicare-covered stay in a Network Hospital you pay: $0 per admission.

Services that are covered for you		**What you must pay** when you get these services
Inpatient mental health care • Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit in a Medicare-certified psychiatric hospital. Prior usage under Medicare is included in the lifetime maximum. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.		You are covered for 150 days each Benefit Period up to the 190-day limit. For each Medicare-covered stay in a Network Hospital you pay: • $0 per admission and each day for days 1 to 150. • 100% of the cost of the Hospital stay for days 151 and over unless a new Benefit Period begins. A Benefit Period begins with the first day of the Medicare-covered Inpatient Hospital stay and ends with the close of a period of 60 consecutive days, during which you are not an Inpatient of a Hospital or Skilled Nursing Facility.
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Covered services include: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services		For each stay in a Medicare-certified Skilled Nursing Facility, you pay per admission: $0 each day for days 1 to 100. There is a limit of 100 days

Services that are covered for you		**What you must pay** when you get these services
• Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician services Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.		for each Benefit Period if your condition requires additional Rehabilitation Services, other types of daily skilled nursing, or other skilled care. If you go over the 100 day limit, you will be responsible for all costs. A Benefit Period begins with the first day of the Medicare-covered Inpatient Hospital stay and ends with the close of a period of 60 consecutive days, during which you are not an Inpatient of a Hospital or Skilled Nursing Facility. When a Network Provider coordinates your admission, Blue Shield 65 Plus waives the 3-day Hospital stay required by Medicare to qualify for coverage. If your admission to an Out-of-Area Skilled Nursing Facility is not authorized or approved by your Network Provider, the Medicare-required 3-day Hospital stay applies.

Services that are covered for you	**What you must pay** when you get these services
Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered Covered services include:	Because there is no limit to the number of days per Hospital stay, this only applies to SNF care.
• Physician services	• You pay $10 for each visit.
• Tests (like X-ray or lab tests)	• You pay $0.
• X-ray, radium, and isotope therapy including technician materials and services	• You pay $0.
• Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations	• You pay $0 for items covered by Medicare.
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	• You pay $0.
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	• You pay $0.
• Physical therapy, speech therapy, and occupational therapy	• You pay $10 for each visit.
Home health agency care Covered services include: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies	You pay $0 for each covered home health visit. Services require Prior Authorization (approval in advance) from your Physician Group or Blue Shield 65 Plus (HMO) to be covered, except for emergency and urgent Out-of-Area services. Please see Urgently Needed

Services that are covered for you		**What you must pay** when you get these services
		Care in this benefit chart for Urgently Needed home health care copayments when you are out of your Plan service area.
Hospice care You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare • Home care Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.		When you enroll in a Medicare-certified hospice program, your hospice services are paid for by Original Medicare, not Blue Shield 65 Plus (HMO). You pay $0 for the Hospice consultation services (one time only).
Outpatient Services		
Important: **Outpatient Services require Prior Authorization (approval in advance)** from your Physician Group or Blue Shield 65 Plus (HMO) to be covered, except for emergency and urgent out-of-area services.		
Physician services, including doctor's office visits Covered services include:		
• Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center		• $10 per visit
• Consultation, diagnosis, and treatment by a specialist		• $10 per visit
• Hearing and balance exams, if your doctor orders it to see if you need medical treatment.		• $10 per visit

Services that are covered for you	**What you must pay** when you get these services
• Telehealth office visits including consultation, diagnosis and treatment by a specialist	• $10 per visit
• Second opinion by another network provider prior to surgery	• $10 per visit
• Outpatient hospital services	• $0 per visit
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	• $10 per visit
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation	You pay $10 per visit for all Medicare-covered services.
Podiatry services Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs	You pay $10 for each Medicare-covered visit.
Outpatient mental health care Covered services include: Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	You pay $10 for each individual or group therapy visit. There is no Calendar-year limit for this benefit.

Services that are covered for you	**What you must pay** when you get these services
Partial hospitalization services "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	You pay $0 for partial hospitalization services. There is no Calendar-year limit for this benefit.
Outpatient substance abuse services	You pay $10 for each individual or group therapy visit. There is no Calendar-year limit for this benefit.
Outpatient surgery, including services provided at ambulatory surgical centers	You pay $0 for each visit to an ambulatory surgical center or an outpatient hospital facility.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	You pay $0 per trip, each way. Note: Although most providers collect the applicable Copayment at the time of service, this may not occur for ambulance services. You may receive a bill for the entire cost of the ambulance service. If this occurs, simply submit your bill to: Blue Shield 65 Plus (HMO) Claims Department PO Box 5014, Woodland Hills, CA

Services that are covered for you		**What you must pay** when you get these services
		91365-9623 Blue Shield will pay for the cost of the covered services, less the applicable copayment. You will receive a separate bill from the provider for the applicable copayment.
Emergency care World-wide coverage.		You pay $50 for each visit to an emergency room. You pay $0 if you are admitted to the Hospital within 24 hours for the same condition. If you need inpatient care at an out-of-network hospital after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital. You have a $10,000 combined annual limit for covered emergency or urgently needed services outside the United States.

Services that are covered for you		**What you must pay** when you get these services
Urgently needed care		
World-wide coverage for treatment of unforeseen illness or injuries.		You pay $25 for each visit to a network urgent care center within your Plan service area. You pay $0 if you are admitted to the Hospital within 24 hours for the same condition. You pay $25 for each visit to an urgent care center, emergency room or physician office that is outside your plan service area. The $25 copay applies to out-of-area urgently needed services such as Outpatient lab work or x-rays, Outpatient Rehabilitation Services visits, home health services and durable medical equipment. You pay $0 for all Out-of-Area Urgently Needed Care if you are admitted to the Hospital within 24 hours for the same condition. You have a $10,000 combined annual limit for covered emergency or urgently needed services outside the United States.

Services that are covered for you		**What you must pay** when you get these services
Outpatient rehabilitation service Covered services include: physical therapy, occupational therapy, speech language therapy, cardiac rehabilitative therapy, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.		You pay $10 for each visit. Please see Urgently Needed Care in this benefit chart for Urgently Needed Outpatient Rehabilitation Services Copayments when you are out of your plan service area.
Durable medical equipment and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.		You pay $0. See "Medicare Part B Prescription Drugs" in this chart for more information on drugs you take using durable medical equipment.
Prosthetic devices and related supplies Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.		You pay $0 for Medicare-covered prosthetic devices and supplies.
Diabetes self-monitoring, training, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.		• You pay $0 for blood glucose monitors, test strips, lancets and glucose-control solutions.

Services that are covered for you		**What you must pay** when you get these services
• One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). For people with diabetes who have severe diabetic foot disease, coverage includes fitting. • Self-management training is covered under certain conditions. • For persons at risk of diabetes: Fasting plasma glucose tests. Coverage will be provided for two screening tests per calendar year for individuals diagnosed with pre-diabetes, and one screening test per year for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested.		• You pay $0 for therapeutic shoes. • You pay $10 for training. • You pay $0 for fasting plasma glucose tests.
Medical nutrition therapy For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.		You pay $10 for each Medicare-covered visit.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include: • X-rays • Radiation therapy • Surgical supplies, such as dressings • Supplies, such as splints and casts • Laboratory tests • Blood. Coverage of storage and administration begins with the first pint of blood that you need • Other outpatient diagnostic tests		You pay $0.
Vision care Covered services include: • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with		• You pay $10 for this care.

Services that are covered for you		**What you must pay** when you get these services
a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year		• You pay $0 for this screening.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. See "Routine Vision services" at the end of this chart for more information.		• You pay $0 for this eyewear.
Preventive Care and Screening Tests		
Important: **Preventive Care and Screening Tests require Prior Authorization (approval in advance)** from your Physician Group or Blue Shield 65 Plus (HMO) to be covered, except for emergency and urgent out-of-area services.		
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.		You pay $0 for the Medicare-covered screening. You pay $10 for the office visit to your Personal Physician or Specialist.

Services that are covered for you		**What you must pay** when you get these services
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. Diagnosis, treatment and management of osteoporosis.		You pay $0 for the Medicare-covered screening. You pay $10 for the office visit to your Personal Physician or Specialist.
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy		You pay $0 for the Medicare-covered screening. You pay $10 for the office visit to your Personal Physician or Specialist. You pay a $0 Outpatient surgery copayment for any Medicare-covered screening performed in an Outpatient facility. You pay a $0 Outpatient surgery copayment for any Medicare-covered colorectal cancer procedure that your physician codes as a diagnostic procedure.
Immunizations Covered services include: • Pneumonia vaccine*		You pay $0 for the Medicare-covered screening.

Services that are covered for you	What you must pay when you get these services
• Flu shots, once a year in the fall or winter* • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk We also cover some vaccines under our outpatient prescription drug benefit. * As explained in Section 2.2, you can get this service on your own, without a referral from your Personal Physician, as long as you get the service from a Network Provider.	You pay $10 for the office visit to your Personal Physician or Specialist.
Mammography screening* Covered services include: • One baseline exam between the ages of 35 and 39 • One screening every 12 months for women age 40 and older *As explained in Section 2.2, you can get this service on your own, without a referral from your Personal Physician, as long as you get the service from a Network Provider. You may make an appointment directly with the radiology facility affiliated with your Personal Physician's Physician Group. Although you do not need to see your Personal Physician first, be sure to discuss your test results with your Personal Physician or Women's Health Specialist.	You pay $0 for the Medicare-covered screening. You pay $10 for the office visit to your Personal Physician or Specialist.
Pap test, pelvic exams, and clinical breast exams* Covered services include: • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months *As explained in Section 2.2, you can get these services on your own, without a referral from your Personal Physician, as long as you get the service from a Network Provider.	You pay $0 for the Medicare-covered screening. You pay $10 for the office visit to your Personal Physician or Specialist.

Services that are covered for you	**What you must pay** when you get these services
Prostate cancer screening exams* For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test *You can get this service on your own, without a referral from your Personal Physician, as long as you get the service from a Network Provider.	You pay $0 for the Medicare-covered screening. You pay $10 for the office visit to your Personal Physician or Specialist.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Contact Member Services for information on how often we will cover these tests.	You pay $0 for the Medicare-covered screening. You pay $10 for the office visit to your Personal Physician or Specialist.
Physician exams A one-time physical exam for members within the first 12 months that they have Medicare Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.	You pay $0 for the Medicare-covered screening. You pay $10 for the office visit to your Personal Physician or Specialist.
Other Services	
Important: **The following 'Other Services' require Prior Authorization (approval in advance)** from your Physician Group or Blue Shield 65 Plus (HMO) to be covered, except for emergency and urgent out-of-area services.	
Dialysis (kidney) Covered services include:	

Services that are covered for you		**What you must pay** when you get these services
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)		• You pay $0 for each treatment billed by a qualified, Medicare-approved dialysis provider, including any drugs used during the procedure.
• Inpatient dialysis treatments (if you are admitted to a hospital for special care)		• Included in your costs for Inpatient Hospital care. Please see the Inpatient Services section of this chart for more information about what you must pay for Inpatient Hospital services.
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)		• You pay $0 for self-dialysis training. • You pay $0 for home dialysis equipment and supplies. • You pay $0 for each visit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:		
• Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services		• You pay $0 for the drugs. You pay $10 for the office visit.
• Drugs you take using durable medical equipment (such as		• If administered by

Services that are covered for you		**What you must pay** when you get these services
nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)		your Personal Physician, you pay $0 for the drugs and $10 for the office visit copayment. If obtained at a retail pharmacy, you pay $0.
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases		• You pay $0
Additional Benefits		
Important: **The following Additional Benefits do NOT require Prior Authorization (approval in advance)** from your Physician Group or Blue Shield 65 Plus (HMO) to be covered.		
Hearing services Hearing aids, hearing aid examination and fitting evaluation. Services may be obtained from the provider of your choice.		You will be reimbursed up to a total of $1,000 every 36 months. Simply submit your bill to: Blue Shield 65 Plus Claims Department PO Box 5014 Woodland Hills, CA 91365-9623

Services that are covered for you		**What you must pay** when you get these services
		Blue Shield will reimburse you for the cost of the covered services, up to the $1,000 limit every 36 months.
Health and wellness education programs These programs include education for qualified Members with conditions such as diabetes and heart disease to assist in self-management of their condition.		
NurseHelp 24/7 When you have a medical concern, one call to our toll-free hotline puts you in touch with a registered nurse who will listen to your concerns and help you toward a solution. Call 1-877-304-0504 (TTY/TDD: 1-800-855-2881) 24 hours a day, 7 days a week.		You pay $0.
LifeReferrals 24/7 Consultants are available 24 hours a day, 7 days a week to offer objective, confidential guidance on personal issues including relationships and stress. Legal, financial and educational resources are available to help balance work and personal matters. Call 1-800-985-2405 (TTY/TDD: 1-800-855-2881) 24 hours a day, 7 days a week		You pay $0.
Member Information 1. A semi-annual Member newsletter that keeps you up to date on health and your health plan. 2. California Advance Healthcare Directive, along with instructions for completion that you may receive by calling our Member Services Department.		You pay $0.

Services that are covered for you		**What you must pay** when you get these services
Blueshieldca.com Our health-in-action web site provides resources to help you make informed decisions about your healthcare, including information from the highly respected Healthwise®. Check out the health library or narrow your search by selecting a specific health topic. NurseHelp 24/7 Online Have a confidential on-on-one online dialogue with a registered nurse, 24 hours a day. Decision Guide Treatment Options Tool Once you enter information about your own health condition, this tool provides you with treatment options relevant to your own circumstances from a database of expert information from medical journals and such highly trusted sources as the American Cancer Society and the American Heart Association.		You pay $0.
Pharmacy section of **blueshieldca.com** Compare generic and Brand Name Drug prices, locate Network Pharmacies or send your questions about prescription or over-the-counter drugs to a pharmacist at the University of California, San Francisco. You'll receive a confidential answer within two business days.		You pay $0.
LifeMAP/Guided Imagery Program The primary objective of the Guided Imagery/LifeMAP program is to provide tools and information necessary to help empower our members to take an active role in their own health management. This support includes attending to mind-body medicine issues, supplying members with immediate relevant medical information, and being aware of the expectation that a health plan will anticipate member needs even before they arise.		You pay $0.

Services that are covered for you		**What you must pay** when you get these services
Direct-to-Physician Program		
Direct-to-Physician is a quarterly clinical messaging program delivered by fax or printed mail to physicians. The messages alert physicians to their patients that are out of compliance with generally accepted clinical practice guidelines regarding their medications and/or care.		You pay $0.
Vision services		

The vision benefits are designed to reduce the cost of vision care while promoting quality eye care coverage services.

Blue Shield of California reserves the right to review all claims to determine whether any exclusions or limitations apply.

Blue Shield of California may use the Services of physician consultants, peer review committees of professional societies and other consultants to evaluate claims.

You can locate a Network Provider by calling the Blue Shield Vision Plan Administrator Customer Service at 1-877-601-9083 [TTY/TDD: 1-800-822-5552], 8 a.m. to 5 p.m., Monday through Friday, or online at www.blueshieldca.com.

You should make an appointment with the Network Provider and identify yourself as a Blue Shield 65 Plus (HMO) Member. The Network Provider will submit a claim for covered services on-line or by claim form. Network Providers will accept Blue Shield's payment for covered Services as payment in full less any applicable Member Copayment, except as noted in the benefit chart below.

When services are provided by a non-Network Provider, you must submit a Vision Service Report Form (claim form C-4669-61) which can be obtained on **www.blueshieldca.com** or from Blue Shield 65 Plus (HMO) Member Services. This form must be completed in full and submitted with all related receipts to:

Blue Shield Vision Plan Administrator
P.O. Box 25208
Santa Ana, California 92799-5208

The Blue Shield Vision Plan Administrator will make payment directly to a Network Provider, or to you for the services of a non-Network Provider, by means of a Blue Shield check.

Network Providers submit claims for payment after their Services have been received. You or your non-Network Providers also submit claims for payment after Services have been received.

Services that are covered for you		**What you must pay** when you get these services

You may select any licensed ophthalmologist, optometrist or optician to provide covered services, including providers outside of California. However, how much you pay may be different depending on whether you use a Network or non-Network provider. See the benefit chart below. A Directory of Network Providers is available on our website located at **www.blueshieldca.com** or from your Group Administrator or from Blue Shield 65 Plus (HMO) Member Services.

If you have a question about Services, providers, benefits, or concerns regarding the quality of care or access to care that you have experienced, you may contact Blue Shield 65 Plus (HMO) Member Services at the number on Page 1 or:

Blue Shield Vision Plan Administrator
Customer Service Department
P.O. Box 25208
Santa Ana, California 92799-5208
1-714-619-4660 or 1-877-601-9083 [TTY/TDD: 1-800-822-5552]
8 a.m. to 5 p.m., Monday through Friday

Vision Benefits

Covered Services under this benefit are limited to the following:

One comprehensive eye examination in a consecutive 12-month period. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive Services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and opthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and, usually, determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.	When received from a <u>Network Provider</u>: You pay $10 per exam. When received from a <u>Non-Network Provider</u>: You pay $10 per exam plus all charges in excess of $70 for an ophthalmologic exam and $60 for an optometric exam.

SECTION 3 What types of benefits are not covered by the plan?

Section 3.1 Types of benefits we do *not* cover (exclusions)

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as a covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. See Chapter 3, Section 5 for more information on clinical research studies.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.

- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, filings or dentures. However, non-routine dental care received at a hospital may be covered.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan. We will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Any services listed above that aren’t covered will remain not covered even if received at an emergency facility.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* may not apply to you.** We will send you the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (Low Income Subsidy Rider), that tells you about your drug coverage. If you don't get this mailing, please call Member Services and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Member Services are on the front cover.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, Blue Shield 65 Plus (HMO) also covers some drugs under the plan's medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Medical benefits chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical benefits chart, what is covered and what you pay*) tells about the benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's Part D benefits. **This chapter explains**

rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a network provider write your prescription. (For more information, see Section 2, *Your prescriptions should be written by a network provider.*)]
- You must use a network pharmacy to fill your prescription. (See Section 3, *Fill your prescriptions at a network pharmacy.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 4, *Your drugs need to be on the plan's drug list*.)
- Your drug must be considered "medically necessary," meaning reasonable and necessary for treatment of your injury or illness. It also needs to be an accepted treatment for your medical condition.

SECTION 2 Your prescriptions should be written by a network provider

Section 2.1 In most cases, your prescription must be from a network provider

You need to get your prescription (as well as your other care) from a provider in the plan's provider network. This person would often be your Personal Physician. It could also be another professional in our provider network if your Personal Physician has referred you for care.

To find network providers, look in the *Provider Directory*.

The plan will cover prescriptions from providers who are not in the plan's network only in a few special circumstances. These include:

- Prescriptions you get in connection with emergency care.
- Prescriptions you get in connection with urgently needed care when network providers are not available.
- Dialysis you get when you are traveling outside of the plan's service area.

Other than these circumstances, you must have approval in advance ("prior authorization") from the plan to get coverage of a prescription from an out-of-network provider.

If you pay "out-of-pocket" for a prescription written by an out-of-network provider and you think we should cover this expense, please contact Member Services or send the bill to us for payment. Chapter 7, Section 2.1 tells how to ask us to pay our share of the cost.

SECTION 3 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 3.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies.

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered by the plan.

Preferred pharmacies are pharmacies in our network where the plan has negotiated lower cost-sharing for members for covered drugs than at other network pharmacies. However, you will still have access to lower drug prices at these other network pharmacies than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs. However, members that use other network pharmacies won't be able to take advantage of the negotiated lower cost-sharing that would be available to them at preferred pharmacies.

Section 3.2 Finding network pharmacies

How do you find a network pharmacy in your area?

You can look in your *Pharmacy Directory*, visit our website (*Pharmacy* section of blueshieldca.com), or call Member Services (phone numbers are on the cover). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to either have a new prescription written by a doctor or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are on the cover) or use the *Pharmacy Directory*.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the FDA to certain locations, require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services.

Section 3.3 Using the plan's network mail service pharmacy

For certain kinds of drugs, you can use the plan's network mail service pharmacy. These drugs are marked as "**mail service" drugs** on our plan's Drug List. (Mail service drugs are drugs that you take on a regular basis, for chronic or long-term medical conditions such as diabetes, asthma, hypertension and chronic heart disease.)

Our plan's mail service pharmacy requires you to order ***at least* a 60-day supply of the drug and *no more than* a 90-day supply**.

To get order forms and information about filling your prescriptions by mail, please call Member Services at the number listed in Section 1. If you use a mail service pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail service pharmacy order will get to you in no more than 14 days. However, sometimes your mail service prescription may be delayed. If you receive notification that there may be a delay in the shipment of your prescription, at no fault of your own, by the mail service pharmacy, please contact Member Services at 1-800-776-4466 (TTY/TDD users should call 1-800-794-1099), 7 a.m. to 8 p.m., seven days a week. A Blue Shield representative will assist you in obtaining a sufficient supply of medication from a local participating retail pharmacy, so you are not without medication until your mail service medication arrives. This may require contacting your physician to have him/her phone or fax a new prescription to the retail pharmacy for the necessary quantity of medication needed until you receive your mail service medication.

If the delay is greater than 14 days from the date the prescription was ordered from the mail service pharmacy and the delay is due to a loss of medication in the mail system, Member Services can coordinate a replacement order with the mail service pharmacy.

Section 3.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of "mail service" drugs on our plan's Drug List. (Mail service drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail service drugs. Some of these retail pharmacies may agree to accept the mail service cost-sharing amount for a long-term supply of mail service drugs. Other retail pharmacies may not agree to accept the mail service cost-sharing amounts for an extended supply of mail service drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of mail service drugs. You can also call Member Services for more information.
2. For certain kinds of drugs, you can use the plan's network **mail service pharmacy.** These drugs are marked as mail service drugs on our plan's Drug List. Our plan's mail service pharmacy requires you to order *at least* a 60-day supply of the drug and *no more than* a 90-day supply. See Section 3.3 for more information about using our mail-order services.

Section 3.5 When can you use a pharmacy that is not in the plan's network?

Your prescription might be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail service pharmacy (these drugs include orphan drugs, high cost and unique drugs or other specialty pharmaceuticals).
- Some vaccines administered in your physician's office that are not covered under Medicare Part B and can not reasonably be obtained at a network pharmacy may be covered under our out-of-network access.

Prescriptions filled at out-of-network pharmacies are limited to a 30-day supply of covered medications.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 4 Your drugs need to be on the plan's "Drug List"

Section 4.1 The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is medically necessary, meaning reasonable and necessary for treatment of your injury or illness. It also needs to be an accepted treatment for your medical condition.

The Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs.

What is *not* on the Drug list?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 8.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

Section 4.2 There are four "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 includes Formulary Generic Drugs (lowest cost-sharing tier)
- Tier 2 includes Formulary Brand Drugs
- Tier 3 includes Non-Preferred Non-Formulary Drugs
- Tier 4 includes Injectables (highest cost-sharing tier)

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List*.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 4.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (*Pharmacy* section of **blueshieldca.com**). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Member Services are on the front cover.

SECTION 5 There are restrictions on coverage for some drugs

Section 5.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you get a drug that works for your medical condition and is safe. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your doctor to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

Section 5.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Using generic drugs whenever you can

A "generic" drug works the same as a brand-name drug, but usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies must provide you the generic version.** However, if your doctor has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your doctor need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes plan approval is required so we can be sure that your drug is covered by Medicare rules. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try safer or more effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**Step Therapy.**"

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 5.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are on the front cover) or check our website (*Pharmacy* section of **blueshieldca.com**).

SECTION 6 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 6.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your doctor think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 5, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of four different cost-sharing tier. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 6.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 6.3 to learn what you can do.

Section 6.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply).
- You can change to another drug.

- You can request an exception and ask the plan to cover the drug in the way you would like it to be covered.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 5 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days.

- **For those who are new members, and are residents in a long-term care facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of 34 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those who have been a member of the plan for more than 90 days**, **and are a resident of a long-term care facility and need a supply right away:**

  We will cover one 34 days supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call Member Services (phone numbers are on the front cover).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your doctor or other prescriber want to ask for an exception, Chapter 9, Section 6.2 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 6.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for the drug. If your doctor or other provider says that you have medical reasons that justify asking us for an exception, your doctor can help you request an exception to the rule.

If you and your doctor want to ask for an exception, Chapter 9, Section 6.2 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 7 What if your coverage changes for one of your drugs?

Section 7.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 in this chapter).
- **Replace a brand-name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 7.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug

List. We will let you know of this change right away. Your doctor will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
    - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
    - Or you and your doctor or other prescriber can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
    - Your doctor will also know about this change, and can work with you to find another drug for your condition.

SECTION 8 What types of drugs are *not* covered by the plan?

Section 8.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." Excluded means that the plan doesn't cover these types of drugs because the law doesn't allow any Medicare drug plan to cover them.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section (unless our plan covers certain excluded drugs). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans unless we offer enhanced drug coverage, for which you may be charged additional premium:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain

- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

We offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan. These drugs are noted in the plan formulary. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this booklet.)

In addition, if you are **receiving extra help from Medicare** to pay for your prescriptions, the extra help will not pay for the drugs not normally covered by a Medicare drug plan. (Please refer to your formulary or call Member Services for more information.) However, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

SECTION 9 Show your plan membership card when you fill a prescription

Section 9.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 9.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 10 Part D drug coverage in special situations

Section 10.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 10, *Ending your membership in the plan*, tells how you can leave our plan and join a different Medicare plan.)

Section 10.2 What if you're a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services.

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 34 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 34-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you

would like it to be covered. If you and your doctor want to ask for an exception, Chapter 9, Section 6.2 tells what to do.

Section 10.3 What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice by November 15 that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that it has drug coverage that pays, on average, at least as much as Medicare's standard drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan's benefits administrator or the employer or union.

SECTION 11 Programs on drug safety and managing medications

Section 11.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.

- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Section 11.2 Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program.

Chapter 6. What you pay for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* may not apply to you.** We will send you the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (Low Income Subsidy Rider), that tells you about your drug coverage. If you don't get this mailing, please call Member Services and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Member Services are on the front cover.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, some drugs are covered under Original Medicare or are excluded by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the four "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are on the cover of this booklet). You can also find the Drug List on our website at www.blueshieldca.com/bsc/medicarepartdplans/formulary/home.jhtml. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan's *Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network and it tells how you can use the plan's mail-order service to get certain types of drugs. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three month's supply).

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the two drug payment stages?

As shown in the table below, there are two "drug payment stages" for your prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 *Initial Coverage Stage*	**Stage 2** *Catastrophic Coverage Stage*
The plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until **your**	Once you have paid enough for your drugs to move on to this last payment stage, **the plan will pay most of the cost** of your drugs for the rest of the

payments for the year total $4,550. (Details are in Section 4 of this chapter.)	year. (Details are in Section 5 of this chapter.)

As shown in this summary of the two payment stages, whether you move on to the next payment stage depends on how much **you and/or the plans spend** for your drugs while you are in each stage.

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Explanation of Benefits"

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.

- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Check the written report we send you.** When you receive an *Explanation of Benefits* in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are on the cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 4.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has four cost-sharing tiers

Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 includes Formulary Generic Drugs (lowest cost-sharing tier)
- Tier 2 includes Formulary Brand Drugs
- Tier 3 includes Non-Preferred Non-Formulary Drugs
- Tier 4 includes Injectables (highest cost-sharing tier)

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List*.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A preferred pharmacy that is in our plan's network
- An other network pharmacy
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's *Pharmacy Directory.*

Preferred pharmacies are pharmacies in our network where the plan has negotiated lower cost-sharing for members for covered drugs than at other network pharmacies. However, you will still have access to lower drug prices at these other network pharmacies than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs.

Section 4.2 A table that shows your costs for a 30-day supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be a copayment.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.

As shown in the table below, the amount of the copayment depends on which cost-sharing tier your drug is in.

Your share of the cost when you get a 30-day supply (or less) of a covered Part D prescription drug from:

	Network Preferred or Other Network pharmacy	**The plan's mail service pharmacy**	**Network long-term care pharmacy**	**Out-of-network pharmacy** (coverage is limited to certain situations; see Chapter 5 for details)
Cost-Sharing Tier 1 (Formulary Generic Drugs)	$5 copay	Not applicable for 30-day supply	$5 copay for a 34-day supply	$5 copay
Cost-Sharing Tier 2 (Formulary Brand Drugs)	$15 copay	Not applicable for 30-day supply	$15 copay for a 34-day supply	$15 copay
Cost-Sharing Tier 3 (Non-Preferred Non-Formulary Drugs)	$45 copay	Not applicable for 30-day supply	$45 copay for a 34-day supply	$45 copay
Cost-Sharing Tier 4 (Injectables)	$45 copay	Not applicable for 30-day supply	$45 copay for a 34-day supply	$45 copay

Section 4.3 A table that shows your costs for a long-term (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. This can be up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

Your share of the cost when you get a long-term (up to a 90-day) supply of a covered Part D prescription drug from:

	Retail Network Preferred Pharmacy or the plan's mail service pharmacy	Other Network pharmacy
Cost-Sharing Tier 1 (Formulary Generic Drugs)	$10 copay	$15 copay
Cost-Sharing Tier 2 (Formulary Brand Drugs)	$25 copay	$45 copay
Cost-Sharing Tier 3 (Non-Preferred Non-Formulary Drugs)	$75 copay	$135 copay
Cost-Sharing Tier 4 (Injectables)	$90 copay (1)	$135 copay

(1) Most injectable drugs are not available through mail service. Please see the plan's formulary for more information.

Section 4.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,550

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$4,550 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what the plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 4.5 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
    - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.

- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs. To find out which drugs our plan covers, refer to your formulary.

The *Explanation of Benefits* that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the $4,550 limit in a year.

We will let you know if you reach this $4,550 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Section 4.5 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

*These payments **are** **included** in your out-of-pocket costs*

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):*

- The amount you pay for drugs when you are in the following drug payment stage:
  - The Initial Coverage Stage.
- Any payments you made during this calendar year under another Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by "Extra Help" from Medicare are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $4,550 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

*These payments are **not** **included** in your out-of-pocket costs*

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay CalPERS for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.

- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.]
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by insurance plans and government-funded health programs such as TRICARE, the Veteran's Administration, the Indian Health Service, or AIDS Drug Assistance Programs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are on the cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you**. The *Explanation of Benefits* report we send to you includes the current amount of your out-of-pocket costs (Section 3 above tells about this report). When you reach a total of $4,550 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3 above tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 5 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 5.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $4,550 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *lower* amount:

- –*either* – coinsurance of 5% of the cost of the drug
- –*or* – the applicable drug tier copay listed in the tables above

- **Our plan pays the rest** of the cost.

SECTION 6 What you pay for vaccinations depends on how and where you get them

Section 6.1 Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical benefits chart (what is covered and what you pay).*
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs.*
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a vaccination shot.

Situation 1: You buy the vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

Situation 2: You get the vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking the plan to pay its share of a bill you have received for medical services or drugs*).
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor less any cost-sharing amount that you need to pay for the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

Section 6.2 You may want to call us at Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination (phone numbers are on the cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 7 Do you have to pay the Part D "late enrollment penalty"?

Section 7.1 What is the Part D "late enrollment penalty"?

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't keep your prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

The penalty is added to your monthly premium. (Members who choose to pay their premium every three months will have the penalty added to their three-month premium.) When you first enroll in Blue Shield 65 Plus (HMO), we let you know the amount of the penalty.

Section 7.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have credible prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, let's say it is 14 months without coverage, which will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2010, this average premium amount is $31.94.
- You multiply together the two numbers to get your monthly penalty and round it to the nearest 10 cents. In the example here it would be 14% times $31.94, which equals $4.47, which rounds to $4.50. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

There are three important things to note about this monthly premium penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for Medicare.

If you are eligible for Medicare and are under 65, any late enrollment penalty you are paying will be eliminated when you attain age 65. After age 65, your late enrollment penalty is based only on the months you do not have coverage after your Age 65 Initial Enrollment Period.

Section 7.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:

- You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this "**creditable drug coverage**." Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is as at least as good as Medicare's.
- If you were without creditable coverage, you can avoid paying the late enrollment penalty if you were without it for less than 63 days in a row.
- If you didn't receive enough information to know whether or not your previous drug coverage was creditable.
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) – *and* – you signed up for a Medicare prescription drug plan by December 31, 2006 – *and* – you have stayed in a Medicare prescription drug plan.
- You are receiving "Extra Help" from Medicare.

Section 7.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Member Services at the number on the front of this booklet to find out more about how to do this.

Chapter 7. Asking the plan to pay its share of a bill you have received for covered services or drugs

SECTION 1 Situations in which you should ask our plan to pay our share of the cost of your covered services or drugs

Section 1.1 If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

4. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you*

have a problem or complaint (coverage decisions, appeals, complaints)) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it's helpful for our plan to process the information faster.
- Either download a copy of the form from our website (myhealthplan on blueshieldca.com) or call Member Services and ask for the form. The phone numbers for Member Services are on the cover of this booklet.

Mail your request for payment together with any bills or receipts to us at this address:

- Blue Shield 65 Plus (HMO), P.O. Box 927, Woodland Hills, CA 91365-9856

Please be sure to contact Member Services if you have any questions. If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If

you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs.)

- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for the medical care or drug, you can make an appeal

If you think we have made a mistake in turning you down your request for payment, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.4 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.6 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send them to the plan

Section 4.1 In some cases, you should send your receipts to the plan to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

In the situation below you should send us receipts to let us know about payments you have made for your drugs:

1. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, the plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore you cannot make an appeal if you disagree with our decision.

Chapter 8. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in Spanish, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are on the front cover).

Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are on the cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a Personal Physician in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are on the cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 of this booklet tells what you can do.

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice", that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us

to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are on the cover of this booklet).

We are always committed to protecting the privacy of your personal and health information. Our Notice of Confidentiality and Privacy Practices describes both your privacy rights as a member and how we protect your personal and health information. To obtain a copy of our privacy notice, you can:

1. Go to blueshieldca.com and click the "Privacy" link at the bottom the homepage.
2. Call the Member Services phone number on your Blue Shield member ID card.
3. Call our Privacy Office toll-free at 1-888-266-8080 [TTY/TDD 1-800-794-1099], 8 a.m. to 3 p.m., Monday through Friday.
4. E-mail us at: blueshieldca_privacy@blueshieldca.com

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in Spanish and in large print.)

If you want any of the following kinds of information, please call Member Services (phone numbers are on the cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- **Information about our network providers including our network pharmacies.**
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the *Provider Directory*.
    - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory.*

- For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are on the cover of this booklet) or visit our website at **blueshieldca.com**.

- **Information about your coverage and rules you must follow in using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the cover of this booklet).

- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are on the cover of this booklet).

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Health Insurance Counseling and Advocacy Program (HICAP). See Chapter 2, Section 3 for contact information.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are on the cover of this booklet).

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2 Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website (http://www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections."
    - Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are on the cover of this booklet). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** *Use this* Evidence of Coverage *booklet to learn what is covered for you and the rules you need to follow to get your covered services.*
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
    - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- ***If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us.*** *Please call Member Services to let us know.*
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it.

- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** *Show your plan membership card whenever you get your medical care or Part D prescription drugs.*

- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Be considerate.*** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*

- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
    - You must pay your plan premiums to CalPERS to continue being a member of our plan.
    - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.

- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the cover of this booklet).*
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

- ***Call Member Services for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
  - Phone numbers and calling hours for Member Services are on the cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Member Services (phone numbers are on the cover of this booklet). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

This chapter explains two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

Their services are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

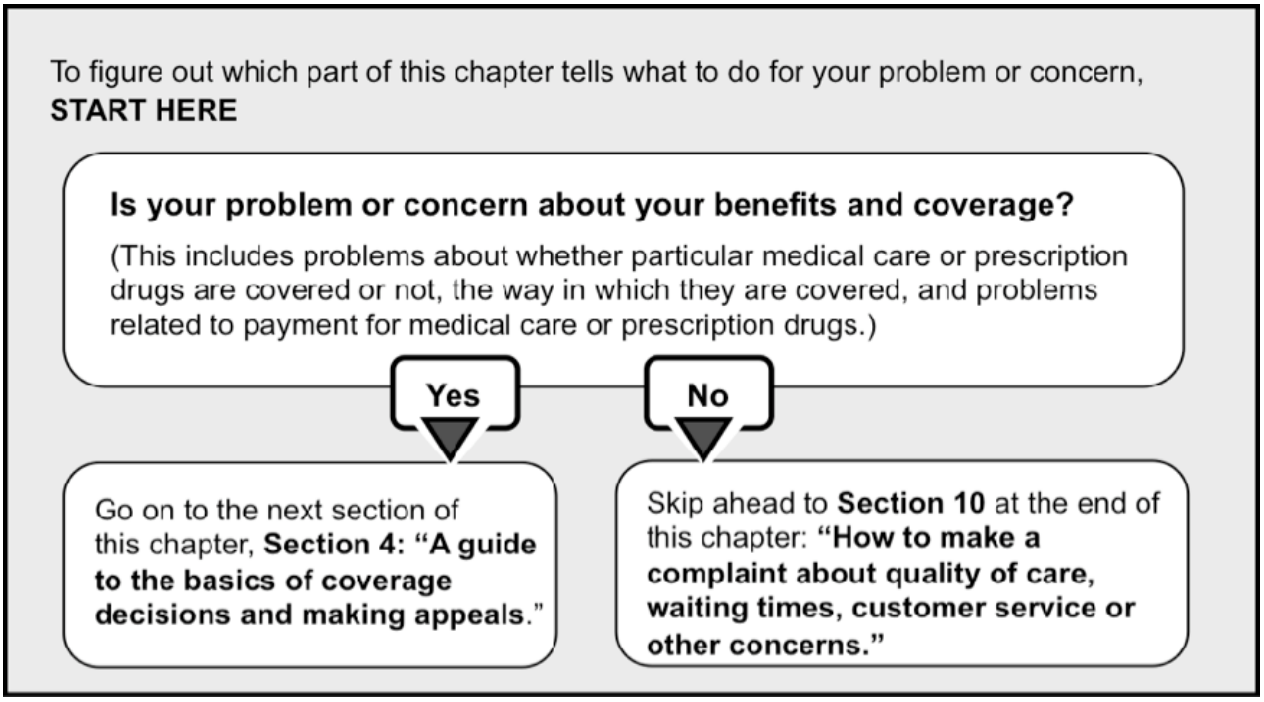
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.



COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service or drug is covered and pay our share of the cost.
- But in some cases we might decide the service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not

connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are on the cover).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **You should consider getting your doctor or other provider involved if possible, especially if you want a "fast" or "expedited" decision.** In most situations involving a coverage decision or appeal, your doctor or other provider must explain the medical reasons that support your request. Your doctor or other prescriber can't request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about "representatives").
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

Section 5 of this chapter	**Section 6** of this chapter	**Section 7** of this chapter	**Section 8** of this chapter
"Your medical care: How to ask for a coverage decision or make an appeal"	"Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"	"How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon"	"How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (Applies to these services only: home health care, skilled nursing facility care and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're still not sure which section you should be using, please call Member Services (phone numbers are on the front cover). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

? Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These are the benefits described in Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
        - Chapter 9, Section 7: *How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
        - Chapter 9, Section 8: *How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
    - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?		
Do you want to find out whether our plan will cover the medical care or services you want?	Has our plan already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	Do you want to ask our plan to pay you back for medical care or services you have already received and paid for?
You need to ask our plan to make a coverage decision for you. Go on to the next section of this chapter, **Section 5.2**.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms A coverage decision is often called an **"initial determination"** or "initial decision." When a coverage decision involves your medical care, the initial determination is called an **"organization determination."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **"fast decision."**

Legal Terms A "fast decision" is called an **"expedited decision."**

How to request coverage for the medical care you want

- Start by writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision about your medical care*.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a "fast decision"

- **A fast decision means we will answer within 72 hours.**

- **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, or if you need to get information to us for the review. If we decide to take extra days, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor's support, our plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: Our plan considers your request for medical care coverage and we give you our answer.

*Deadlines for a **"fast"** coverage decision*

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more days under certain circumstances. If we take extra days, it is called "an extended time period."
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after

we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision*

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request.**
  - We can take up to 14 more days ("an extended time period") under certain circumstances.
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If our plan says no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms

When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact our plan and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal you, your representative, or in some cases your doctor must contact our plan.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Make your standard appeal in writing by submitting a signed request.**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information in your appeal and add more information if you like.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make an oral request)

Legal Terms	A "fast appeal" is also called an **"expedited appeal."**

- If you are appealing a decision our plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will automatically agree to give you a fast appeal.

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were being fair and following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

*Deadlines for a **"fast" appeal***

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
    - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more days.**
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have sent your appeal to the Independent Review Organization for a Level 2 Appeal.

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more days.**
    - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have sent your appeal to the Independent Review Organization for a Level 2 Appeal.

<u>Step 3:</u> If our plan says no to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When

we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How to make a Level 2 Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

*If you had a "fast" appeal at Level 1, you will also have a **"fast" appeal** at Level 2*

- If you had a fast appeal to our plan at Level 1, the review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more days**.

*If you had a "standard" appeal at Level 1, you will also have a **"standard" appeal** at Level 2*

- If you made a standard appeal to our plan at Level 1, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more days**.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 days after we receive the decision from the review organization.
- **If this organization says no to your appeal**, it means they agree with our plan that your request for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking our plan to pay you for our share of a bill you have received for medical care?

If you want to ask our plan for payment for medical care, start by reading Chapter 7 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical benefits chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's *List of Covered Drugs (Formulary)* and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	A coverage decision is often called an **"initial determination"** or "initial decision." When the coverage decision is about your Part D drugs, the initial determination is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs* but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

Which of these situations are you in?			
Request a Coverage Decision:			***Make an Appeal:***
Do you want us to make an exception to the rules or restrictions on our plan's coverage of a drug?	Do you want to ask us to cover a drug for you? (For example, if we cover the drug but we require you to get approval from us first.)	Do you want to ask us to pay you back for a drug you have already received and paid for?	Has our plan already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
⇩	⇩	⇩	⇩
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our plan's *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to all of our drugs. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.
   - You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

2. **Removing a restriction on the plan's coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on the plan's *List of Covered Drugs* (for more information, go to Chapter 5 and look for Section 5).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

   - The extra rules and restrictions on coverage for certain drugs include:
     - *Being required to use the generic version* of a drug instead of the brand-name drug.
     - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")]
     - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
   - If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If your drug is in the Non-Preferred Non-Formulary Drug tier you can ask us to cover it at the cost-sharing amount that applies to drugs in the Formulary Brand Drugs tier. This would lower your share of the cost for the drug.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask our plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a **"fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you

back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our plan to pay you back for a drug,** start by reading Chapter 7 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See Sections 6.2 and 6.3 for more information about exception requests.

If your health requires it, ask us to give you a "fast decision"

Legal Terms	A "fast decision" is called an **"expedited decision."**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
- The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: Our plan considers your request and we give you our answer.

*Deadlines for a **"fast"** coverage decision*

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision*

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**

- If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- If we approve your request to pay you back for a drug you already bought, we are also required to **send payment to you within 30 calendar days** after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If our plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms

When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact our plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact our plan.**
  - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your Part D prescription drugs.*
- **Make your appeal in writing by submitting a signed request.**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Terms	A "fast appeal" is also called an **"expedited appeal."**

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast decision" in Section 6.4 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

*Deadlines for a **"fast" appeal***

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.

- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called

your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

*Deadlines for **"fast" appeal** at Level 2*

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

*Deadlines for **"standard" appeal** at Level 2*

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
    - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
    - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to s**end payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about the plan's coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay)*.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**." Our plan's coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - What to do if you think you are being discharged from the hospital too soon.

Legal Terms	The written notice from Medicare tells you how you can **"make an appeal."** Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (Section 7.2 below tells how to make this appeal.)

2. **You must sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048). You can also see it online at http://www.cms.hhs.gov

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

Step 1: Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly.

Legal Terms	A "fast review" is also called an **"immediate review"** or an **"expedited review."**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms	A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.
- During this review process, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms	This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at http://www.cms.hhs.gov/BNI/

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **our plan must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying *no* to your appeal is also called *turning down* your appeal.) If this happens, **our plan's coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this

review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **Our plan must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **Our plan must continue providing coverage** for your hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. This is called "upholding the decision." It is also called "turning down your appeal."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited" review** (or **"expedited appeal"**).

Step 1: Contact our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: Our plan does a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, our plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If our plan says no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If our plan says *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with our plan that your planned hospital discharge date was medically appropriate. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major

operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay)*.

When our plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *our plan will stop paying its share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal or decision**. This section tells you how to ask.

Section 8.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
   - The written notice tells you the date when our plan will stop covering the care for you.

Legal Terms	In this written notice, we are telling you about a **"coverage decision"** we have made about when to stop covering your care. (For more information about coverage decisions, see Section 4 in this chapter.)

   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling what you can do, the written notice is telling how you can **"make an appeal."** Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care. (Section 8.3 below tells how you can make an appeal.)

Legal Terms	The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-

	2048). Or see a copy online at http://www.cms.hhs.gov/BNI/

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or "Level 1 Appeal."

<u>Step 1:</u> Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for our plan to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- During this review process, you will also get a written notice from the plan that gives our reasons for wanting to end the plan's coverage for your services.

Legal Terms	This notice explanation is called the "**Detailed Explanation of Non-Coverage."**

<u>Step 3:</u> Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **our plan must keep providing your covered services for as long as it is medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** Our plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **Our plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Our plan must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited" review** (or **"expedited appeal"**).

Step 1: Contact our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: Our plan does a "fast" review of the decision we made about when to stop coverage for your services.

- During this review, our plan takes another look at all of the information about your case. We check to see if we were being fair and following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our plan says no to your fast appeal,** then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its share of the costs of this care.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If our plan says *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 1 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we

said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent

Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer services, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has dealt with you?
- Do you feel you are being encouraged to leave our plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
- Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from our plan

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints (continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. You may call Blue Shield 65 Plus (HMO) Member Services at 1-800-776-4466 [TDD 1-800-794-1099] 7 a.m. to 8p.m., seven days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:
  - Step 1: File a Grievance

    To begin the process, call a Member Services representative within 60 days of the event and ask to file a Grievance. You may also file a Grievance in writing within 60 days of the event by sending it to:

    Blue Shield 65 Plus (HMO) Appeals & Grievances
    PO Box 927
    Woodland Hills CA 91365-9856.

    FAX: (818) 228-5116

    If contacting us by Fax or by Mail, please call us to request a Blue Shield 65 Plus (HMO) **Appeals & Grievance Form**.

    We will let you know that we received the notice of your concern within 5 days and give you the name of the person who is working on it. We will normally resolve it within 30 days.

If you ask for a "Fast Grievance" because we decided not to give you a "Fast Initial Decision" or "Fast Appeal" or because we asked for an extension on our Fast Initial Decision or Fast Appeal, we will forward your request to a Medical Director who was not involved in our original decision. We may ask if you have additional information that was not available at the time you requested a Fast Initial Decision or Fast Appeal.

The Medical Director will review your request and decide if our original decision was appropriate. We will send you a letter with our decision within 24 hours of your request for a "Fast Grievance."
We must address your Grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

- Step 2: Grievance Hearing

  If you are not satisfied with this resolution, you may make a written request to the Blue Shield 65 Plus (HMO) Appeals & Grievances for a Grievance hearing. Within 31 days of your written request, we will assemble a panel to hear your case. You will be invited to attend the hearing, which includes an uninvolved physician and a representative from the Appeals and Grievance Resolution Department. You may attend in person or by teleconference. After the hearing, we will send you a final resolution letter.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 days after you had the problem you want to complain about.

- **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms	What this section calls a **"fast complaint"** is also called a **"fast grievance."**

<u>Step 2:</u> We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 days, but we may take up to 44 days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

Chapter 10. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in Blue Shield 65 Plus (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the group's Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during your Employer Group's Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during your **Employer Group's Open Enrollment Period**.

- **When is your Employer Group's Open Enrollment Period?** Your **Employer** Group will let you know when your open enrollment period begins and ends and the effective date of coverage.
  - **What type of plan can you switch to during the Medicare Advantage Open Enrollment Period?** Each year, your **Employer** Group will let you

know what plan choices are available to you and when your membership in this plan will end should you choose to end your membership

Section 2.2 You can end your membership during the Annual Enrollment Period

In addition to your former employer group's Open Enrollment Period, you could also end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is another time when you can review your health and drug coverage and make a decision about your coverage for the upcoming year. **However, before you make any change during this period, please contact Member Services at the number on your ID Card or contact your group benefits administrator as making a change outside of their Open Enrollment Period could affect your eligibility for their retiree coverage.**

- **When is the Annual Enrollment Period?** This happens every year from November 15 to December 31.

- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Original Medicare *with* a separate Medicare prescription drug plan.
    - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

      Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is at least as good as Medicare's standard prescription drug coverage.)

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period, but your plan choices are more limited

In addition to your former employer group's Open Enrollment Period, you have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**. **However, before you make any change during this period, please contact Member Services at the number on your ID Card or contact your group benefits administrator as**

making a change outside of their Open Enrollment Period could affect your eligibility for their retiree coverage.

- **When is the Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.

- **What type of plan can you switch to during the Medicare Advantage Open Enrollment Period?** During this time, you can make *one* change to your health plan coverage. However, you may *not* add or drop prescription drug coverage during this time. Since you are currently enrolled in a Medicare Advantage plan with prescription drug coverage, this means that you can enroll in *either*:
  - Another Medicare Advantage plan with prescription drug coverage.
  - – *or* – Original Medicare and a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will end on the first day of the month after we get your request to change plans.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Blue Shield 65 Plus (HMO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact your group benefits administrator, the plan, call Medicare, or visit the Medicare website (http://www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.
  - If you are eligible for Extra Help with paying for your Medicare prescriptions.
  - If you live in a facility, such as a nursing home.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:

- Another Medicare Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is at least as good as Medicare's standard prescription drug coverage.)

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the cover of this booklet).
- Contact **CalPERS** at **888 CalPERS** (888-225-7377) [TTY/TDD: 1-800-735-2929] 8 a.m. to 5 p.m., Monday through Friday, for more information.
- You can find the information in the ***Medicare & You 2010*** handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another health plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). One exception is when you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact CalPERS or Blue Shield 65 Plus (HMO) Member Services and ask to be disenrolled from our plan.

The table below explains how you should end your membership in our plan. Before you take any of the actions described in the table below, please contact CalPERS at **888 CalPERS** (888-225-7377) [TTY/TDD: 1-800-735-2929] 8 a.m. to 5 p.m., Monday through Friday, so that they can explain any consequences changing plans may have on your eligibility for a retiree plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare Advantage plan.	• Enroll in the new Medicare Advantage plan. You will automatically be disenrolled from Blue Shield 65 Plus (HMO) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from Blue Shield 65 Plus (HMO) when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Contact Member Services and ask to be disenrolled from the plan (phone numbers are on the cover of this booklet).** • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Blue Shield 65 Plus (HMO) when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave Blue Shield 65 Plus (HMO), it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail service pharmacy.

- **If you are hospitalized on the day that your membership ends, you will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Blue Shield 65 Plus (HMO) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Blue Shield 65 Plus (HMO) must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.

- If you move out of our service area for more than six months.

    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.

- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.

  - We cannot make you leave our plan for this reason unless we get permission from Medicare first.

- If you let someone else use your membership card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay your portion of the plan premium to your former employer group, your group will request that you be disenrolled from the plan. Your former employer group is required to notify you if it plans to end your membership. Contact CalPERS at **888 CalPERS** (888-225-7377) [TTY/TDD: 1-800-735-2929] 8 a.m. to 5 p.m., Monday through Friday, for more information.
- If your former employer group's Agreement with us terminates for any reason, your membership ends on the same date. Your former employer group is required to notify you in writing if its Agreement with us terminates.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are on the cover of this booklet).
- Contact **CalPERS** at **888 CalPERS** (888-225-7377) [TTY/TDD: 1-800-735-2929] 8 a.m. to 5 p.m., Monday through Friday, for more information.

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Chapter 11. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Chapter 12. Definitions of important words

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Benefit Period – For both our Plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,550 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs Medicare. Chapter 2 explains how to contact CMS.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs or services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs or services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific drugs or services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug or service.

Cost-sharing Tier – Every drug on the list of covered drugs is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a medical service or drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the service or prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our Plan.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to cover, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug expenses, have reached $4,550, including amounts you've paid and what our Plan has paid on your behalf.

Initial Decision (also called Initial Determination) – In general, a decision by Blue Shield 65 Plus (HMO) or a person such as your Personal Physician or Physician Group acting on the Plan's behalf, to approve or deny a payment for a service or a request for provision of service made by you or on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

List of Covered Drugs (Formulary or "Drug List") – A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy/Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Medically Necessary – Drugs, services, or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Other Network Pharmacy – A network pharmacy that offers covered drugs to members of our Plan at higher cost-sharing levels than apply at a preferred network pharmacy.

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Other Network Pharmacy – A network pharmacy that offers covered drugs to members of our Plan at higher cost-sharing levels than apply at a preferred network pharmacy.

Out-of-network Provider or Out-of-network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-network Pharmacy – A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – see "Medicare Advantage (MA) Plan".

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Personal Physician – A health care professional you select to coordinate your health care. Your Personal Physician is responsible for providing or authorizing covered services while you are a plan member. Chapter 3 tells more about Personal Physicians.

Preferred Network Pharmacy – A network pharmacy that offers covered drugs to members of our Plan at lower cost-sharing levels than apply at an Other network pharmacy.

Preferred Provider Organization Plan – A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a

specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2 for information about how to contact the QIO in your state and Chapter 9 for information about making complaints to the QIO.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care – Urgently needed care is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger. Because of the situation, it isn't reasonable for you to obtain medical care from a network provider.

Blue Shield 65 Plus (HMO)
for CalPERS Service Area By County

Refer to Chapter 1, Section 2.3 for a full list of zip codes in each of the partial counties in the service area.

Blue Shield of California

Blue Shield 65 Plus (HMO)

For inquiries, issues or requests, please contact
Blue Shield 65 Plus (HMO) Member Services:

(800) 776-4466 (Calls to these numbers are free)

TTY/TDD users call: **(800) 794-1099**

7:00 a.m. to 8:00 p.m., seven days a week

or go to our plan website at **blueshieldca.com/calpers**

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